

Kenai Spine

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Orthopaedic Spine Surgeon
Steven C. Humphreys, M.D.
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AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

Patient's Full Legal Name: _____ **D.O.B.** _____

Former Name (s): _____

I authorize Kenai Spine to: **Release To** **Obtain From:**

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

Information to be Released or Obtained:

For the Purpose of:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Emergency Reports | <input type="checkbox"/> EKG Reports | <input type="checkbox"/> Further Medical Treatment |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> X-Ray Films | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other: | | | |

Date(s) of service: _____

***note* there is a \$10.00 charge for X-Ray copies on Disc. With the exception of a X-ray disc, the first copy of medical record is free of charge to patients. After first copy, it is \$.10 per page charge.**

I acknowledge that the information to be released or obtained may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing in the Kenai Spine business office. I understand that the revocation will not apply to the information that has already been released or obtained in response to this authorization, and that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In absence of a revocation, this specific authorization will expire on _____ (if left blank, it will expire 90 days from date of signature). MAXIMUM time for authorization is one year from date of signature.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

I understand authorizing the use of the disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment.

Patient or Representative Signature **Date**

Witness **Date**